

MEDICAL REFORM

Newsletter of the Medical Reform Group of Ontario

Medical Reform Group of Ontario, P.O. Box 158, Station D, Toronto, Ontario M6P 3J8 (416) 588-9167

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How should MDs be paid?

Fall meeting to debate the alternatives

The Medical Reform Group's fall general meeting, set for Wednesday November 18, will be looking at how physicians should be paid. The debate has been framed around the topic "Is There a Future for Fee-for-Service?" There are several articles in this issue addressing the topic, and at the meeting a panel of speakers will debate the issue before turning the discussion over to the floor.

The general meeting will be at the Davenport-Perth Community Health Centre, 1900 Davenport Road, Toronto. Dinner will be catered in. If you intend to come for the dinner, please call (416) 588-9167 by Friday November 13 to say that you are coming, because we have to know how many dinners to order. Dinner will be from 6:30 to 7:30. Business items will be from 7:30 to 8:00 p.m. The discussion of fee-for-service and the alternatives will begin at 8 p.m. The registration fee for the meeting, including dinner, will be \$10.▼

IN THIS ISSUE

Fall meeting.....	1
Resource Allocation Group.....	1
Primary Care Working Group.....	1
Family Physicians' Group analysis ..	3
Hamilton Student Meeting.....	3
Whither HSOs?.....	4
New Mailing Address.....	4
Steering Committee Report.....	6

Resource Allocation Group

Physician Reimbursement: A Point-by-Point Analysis

BACKGROUND

The Medical Reform Group has previously addressed the issue of mechanisms for reimbursement for physicians. Our position has been that a variety of mechanisms of funding should be encouraged. Their performance should be studied with a view to choosing the mechanism or mechanisms that work best. The Resource Allocation Group feels that this position is no longer satisfactory. The environment has changed in two ways in the last five years. First, the financial pressure on the system has become much greater, and efficiency has thus emerged as a greater priority. Second, the criticisms of fee-

for-service reimbursement have increased and governments seem much more ready to consider alternative reimbursement mechanisms. It would be desirable for the MRG to take a clear and strong position in the ongoing debate.

In the remainder of this document we present the advantages and disadvantages of a variety of reimbursement mechanisms and possible strategies for dealing with the problems. We then present our conclusions, the implications for MRG policy, and issues that require further discussion. The reader should note that in the following discussion we are dealing only with strategies for reimbursement of primary care.

Continued on Page 2

Primary Care Working Group

Further Analysis on Payment

The Primary Care Working Group has examined the paper produced by the Resource Allocation Working Group. We would like to congratulate them on putting out their initial attempt to define the problems and benefits of the three main methods of physician payment. We would also like to comment on this paper.

Fee-for-Service

We would agree with the analysis of the fee-for-service system. It encourages extra-servicing, and leads to a mentality of extra-billing, since it suggests that there *should* be a charge for every act. On the other hand, under this system, as opposed to the other two, you at least know the service has been delivered (barring outright fraud). Of course, how well the service was delivered or

whether it was necessary are unknown.

The analysis does not point out an advantage previously agreed upon: the fee-for-service system can be manipulated to reward services given in underserved areas, or in providing services that need to be reinforced, such as Pap smears for high risk women. In many ways, this strategy is made easier through fee-for-service than it is in the other modes of payment.

Capitation

Capitation represents an in-between position between fee-for-service and salary. It allows for the advantages of ownership. We feel that this should be recognized. Most physicians spend a lot more time at their offices doing non-

Continued on Page 5

FEE-FOR-SERVICE

Advantages

- i) Private-practice physicians are self-employed and maintain considerable autonomy.
- ii) Working harder is financially rewarded.
- iii) The system is in place and there are therefore no political costs associated with change.

Disadvantages

- i) By far the most negative aspect of fee-for-service is that it encourages unnecessary utilization. This unnecessary utilization is inevitably inefficient and

wasteful, and may also have adverse health consequences.

ii) Physicians are discouraged from spending time with their patients. Conversely, spending minimal time with each patient and thus seeing more people in a given period of time is rewarded. The incentive to spend as little time as possible with each patient may have adverse health consequences.

iii) Related to the above, physicians who maintain a conscientious practice and a commitment to spend necessary time with patients are penalized. This is particularly true in periods such as the recent few years when increases in reimbursement per service are less than inflation and many physicians respond by seeing more patients per unit time.

iv) The structure of the current fee schedule reflects the political power of different physician groups within the OMA tariff committee and does not provide incentives for the provision of efficient, effective care.

Strategies for Dealing with Disadvantages

- i) The reimbursement schedule could be manipulated to reward effective, efficient care.
- ii) The rewards system could reflect a system of relative values that would include the time required for a service, the intellectual effort involved, and the level of skill required.

CAPITATION

Advantages

- i) Working harder is financially rewarded.
- ii) Capitation removes the perverse incentive to deliver unnecessary services that is part of fee-for-service.
- iii) There is considerable scope for rational, advanced planning of resource allocation.
- iv) There is considerable scope for influencing the distribution of physicians in a positive way.

Disadvantages

- i) Capitation provides an incentive for underservicing.
- ii) There is an incentive for expanding one's practice, possibly beyond the level that allows one to deliver consistent, high-quality care.

iii) There is an incentive to spend minimal time with patients.

iv) There is a financial incentive to accept only healthy patients.

Strategies for Dealing with Disadvantages

- i) Any capitation scheme should have a maximum number of patients that any practitioner can enrol.
- ii) There should be differential reimbursement for enrolling patients that depends on age, socioeconomic status, and any other variables that determine health care utilization that can be easily identified and measured.
- iii) Any capitation system should be introduced on a widespread basis. This will help prevent physicians reimbursed on capitation schemes from selectively enrolling healthy patients.

SALARY

Advantages

- i) Salary removes the perverse incentive to deliver unnecessary services that is part of fee-for-service.
- ii) Physicians are guaranteed a regular income.
- iii) There is no disincentive for taking time with patients to provide the most effective care.
- iv) There is considerable scope for rational, advanced planning of resource allocation.
- v) There is considerable scope for influencing the distribution of physicians in a positive way.

Disadvantages

- i) The perverse incentive of a salary system is that it tempts physicians to minimize their clinical activity.

Strategies for Dealing with Disadvantages

- i) Standards of the appropriate quantity and quality of clinical services that each practitioner should deliver must be developed. Those delivering services should be involved in establishing these standards, as should those paying for services (the government) and consumers. In the event of disagreement between those delivering services and those paying for them that defies negotiated resolution, an independent arbitration mechanism should be established.

Medical Reform

Medical Reform is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$25/year. Arrangements to purchase multiple copies of individual newsletters or of annual subscriptions at reduced rates can be made.

Articles and letters on health-related issues are welcomed. Submissions should be typed (preferably double-spaced), or submitted on IBM-compatible computer disks (any program, but tell us which program you used.)

Correspondence should be sent to Medical Reform, P.O. Box 171, Station D, Toronto M6P 3J8. Phone: (416) 588-9167 Fax: (416) 588-3765.

Opinions expressed in *Medical Reform* are those of the writers, and not necessarily those of the Medical Reform Group of Ontario.

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The Medical Reform Group of Ontario is an organization of physicians, medical students, and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

1. Health Care is a Right

The Universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

2. Health is Political and Social in Nature

Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

3. The Institutions of the Health System Must Be Changed

The health care system should be structured in a manner in which the equally valuable contributions of all health care workers in recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

ii) Once standards have been set, the volume and quality of clinical services should be monitored.

CONCLUSIONS

The actual effect of the different methods of reimbursement on costs and health outcomes is unknown. Research testing the different strategies, particularly randomized trials, would be highly desirable. Even in the absence of definitive evidence, however, we believe that a clear policy can be ad-duced.

In an era of severe cost constraints, the major disadvantage of fee-for-ser-vice practice looms large. The provision of unnecessary services is both costly and may lead to adverse health out-comes. Health outcomes may also be adversely effected by the incentive to spend as little time as possible with each patient. There is no good strategy for dealing with the perverse incentive to deliver unnecessary care that is as-sociated with fee-for-service. Capitation and salary arrangements remove the in-centive to deliver unnecessary care, allow for more rational health planning, and strategies to deal with their inherent problems are relatively readily imple-mented. We therefore believe that a mas-sive shift to capitation and salaries as a means of reimbursement for primary care in Canada is highly desirable. The massive increase in capitation and salaried reimbursement should be ac-companied by institution of strategies to minimize their adverse effects. Pending the shift to capitation and salary, changes that would minimize the negative effects of fee-for-service should be made.

ISSUES THAT REMAIN TO BE RESOLVED

- i) What details of the implementation of capitation and salary systems are impor-tant to define at this point?
- ii) How should we fund secondary specialist care?
- iii) How should the transition to salary and capitation be engineered?
- iv) What should be the mix between capitation and salary in a restructured system?

The Resource Allocation Group will continue to meet to discuss these issues. Please let me know what you think of this summary. ▼

Family physicians' group looks at alternate payment mechanisms

In response to widespread criticism of the fee-for-service payment mechanism, the College of Family Physicians of Canada (which is really an association, not a college) has begun looking at alternate payment mechanisms. The CFPC's position is that "family physicians should have the right to choose the method by which they are remunerated for their patient care activities". The CFPC says that the fee-for-service system has not, "in some respects, served family physicians very well, because it was procedurally oriented and volume-driven", but states that there are "major deficiencies in the alternate payment mechanisms currently being offered." It also notes that "there is still considerable support among fam-ily physicians for the fee-for-service pay-ment method."

The CFPC's position paper on alter-nate payment mechanisms calls for a pluralistic system rather than a single payment mechanism. It says that pay-ment methods should not be solely volume-driven, but should incorporate incentives to enhance quality, availability and comprehensiveness of care. A fair dispute resolving process is called for. The position paper says that family physicians should play a key role in the administration of the health care system.

According to the CFPC, "Account-ability should include not only the finan-cial audit of services rendered but a critical appraisal of what we are present-ly doing. We must look at the cost effec-tiveness of walk-in clinics, home care services, high tech and special service clinics."

The CFPC says that private funding should not be precluded, and says that is-sues such as user fees "will have to be addressed."

The CFPC proposes a "blended" pay-ment mechanism with four components: (a) Base (b) Occupational Costs (c) Non-Volume Modifiers, and (d) Volume Modifiers. These four components could be weighted at different levels "depend-ing on the desires of those involved" and could be negotiated with governments in a fashion similar to what is in place now. Base pay would be based on a minimum of 35 hours per week, with allowance for statutory holidays, vacations, and paid

continuing medical education. Occupa-tional costs include office space, equip-ment costs, and staffing. Non-volume modifiers include isolation allowance, obstetrics, maintenance of certification, teaching, on-call, nursing home and residential care, hospital practice, hospi-tal committees, and maintenance of spe-cial skills. Volume modifiers would be based on RBRV units. E.g. 0 - 1000 RBRV units would be category I and be paid \$X, 1000 - 2000 RBRV units would be category II and paid \$Y. As volume increased beyond what is con-sidered possible for quality care the in-cremental increase from category to category would decrease or alternatively no increase would be given above a cer-tain number of RBRV units.

These components would be blended together to arrive at a total remuneration package.

The CPRC says that the proposed model would be far less volume-driven than the current fee-for-service system, but it would guarantee that a certain volume of work had to be accomplished to earn the base salary. There would be incentives for physicians to practise in remote and rural areas. ▼

Hamilton student meeting

Don Woodside, a former Steering Committee member, gave a history of the Medical Reform Group to the first meeting of the Hamilton chapter on September 22. In the wide-ranging discussion that fol-lowed, topics discussed included fee-for-service and alternate pay-ment mechanisms, private health insurance, opting out in British Columbia, other threats to medicare, the health professions legislation, current position of the Ministry of Health and the Ontario Medical Association, supply of physicians, and roles and oppor-tunities for other health care workers. (Two of the students at-tending were nurses and one was a physiotherapist). Further meetings are planned for later in the fall. ▼

Whither HSOs?

by Rosana Pellizzari

Physicians in private practice provide approximately 97% of primary health care services in Ontario and bill over \$1.6 billion (1991/92) to the taxpayers annually. Alternatives to the private practice model have existed in this province for the past thirty years, sometimes at the whim of the health minister of the day, often as a result of well organized community efforts.

By 1991, the Ministry of Health Annual Report noted that there was 81 Health Service Organizations (HSOs) and 36 Community Health Centres (CHCs) serving a combined population of 645,000 people. The HSO programme provided an alternative to fee for service payment by providing remuneration based on a per capita calculation. Three types of HSOs existed: physician sponsored, university sponsored and university sponsored. In addition, HSOs received incentive payments, based on a comparison of their hospitalization rate to local rates, theoretically meant to encourage more health promotion and ambulatory care.

CHCs, on the other hand, were funded to provide health promotion and primary health care to populations who either experienced barriers to accessing appropriate care, or who suffered greater burdens of illness. They are all community sponsored, and receive global budgets based on programming. Physicians work as members of interdisciplinary teams, and are salaried.

Since 1991, another 11 CHCs have been funded, bringing the total to 47. A moratorium on HSO applications was put into effect in 1990, at the initiation of a program review, and is still in place to date. The Ministry produced a report entitled "New Beginnings," which outlined several major reforms to the HSO program, including the demise of the incentive payments which had been seriously criticized. However, this was followed closely by the landmark Framework Agreement between the Ontario Medical Association (OMA) and the Ministry of Health, establishing the OMA as the bargaining agent for all physicians in the province and estab-

lishing the Joint Management Committee (JMC).

Historically, the relationship between HSOs and the OMA was not one of mutual trust and support. Physician-sponsored HSOs felt that the OMA represented, and favoured, fee for service payment for its members. With the agreement, however, the OMA has assumed the responsibility of negotiating the HSO contracts. Interim contracts were negotiated for the period ending January, 1993 but it is unclear what the OMA's position will be when its team meets with Ministry representatives to discuss any future contract. It is known that they have refused to discuss variable capitation rates, one of the reforms recommended in "New Beginnings".

In the meantime, the Ministry of Health supported a collaborative strategic planning process for the future of CHCs in the province. The process included an evaluability assessment, to determine whether the program was evaluable, and outline steps to allow future evaluation of this model of health care delivery. That process has recently been completed and reports are due to be released soon. The demand for CHCs has mushroomed, and communities throughout the province have begun the established process of community research and feasibility assessment required for funding.

It is unclear how primary health care will be delivered in this province in the future. The recognition of midwifery can be interpreted as a liberalizing and destabilization of physician-centred care. Health Minister Frances Lankin has stated her support for both HSOs and CHCs but the recent OMA-MOH Agreement has firmly entrenched the HSOs in the physician camp, effectively limiting public debate and discussion. These next few months are crucial for the future of the HSO programme. It is ironic that despite the international and historic support for capitation as a preferred model for physician remuneration, capitation in this province is undergoing such a struggle.

Nationally, links between provincial community health centres and health cooperatives are strengthening. A National Association, which includes Quebec, has had organizational meetings and is planning to hold an inaugural conference, in Manitoba, in the fall of 1993. The Association of Ontario Health Centres (AOHC) is involved in this effort. The OAHC has been collaborating with the Ministry of Health in the strategic planning process for CHCs and will be instrumental in organizing a dialogue and response to the recommendations contained in the upcoming reports.▼

New mailing address

The post office which has housed the Medical Reform Group's post office box for the last decade has been closed down. Canada Post is shutting down post offices and slashing service right across the country, and our post office was one of the victims. Cynics maintain that the government's strategy is to keep cutting postal service until the public is ready to accept privatization of the Post Office. Be that as it may, the MRG now has a new mailing address: P.O. Box 158, Station D, Toronto M6P 3J8. As announced in the last issue, there is also a new fax number: (416) 588-3765. The phone number remains the same: (416) 588-9167. However, the old MRG post office box will still remain in operation as well until the end of the year, so it's OK to use those return envelopes to send in your membership.

medical things (paperwork, maintenance, etc.) than shows up in the usual stats. The smooth functioning of the system depends on this extra effort, beyond what is formally paid for.

The question was raised about underservicing under capitation. We feel there are two checks on this. The first is that the patient may just go elsewhere. The second is the system of negation, whereby the costs of visits elsewhere are subtracted from the income of the capitated physician. This latter is an even stronger penalty now, as we approach full-cost negation.

Associated with underservicing, is the concern that a physician could "pad" his/her practice with healthy patients, and thus bilk the system. While this is possible, remember that patients can go elsewhere if they are dissatisfied with the service they are receiving or not receiving. Also, with capitation, the funding goes with the patient (a system, incidentally, which is being adopted for the institutionalized elderly across the province). This is actually an advantage. If it were government policy to increase the number of capitated physicians, it could help to solve the problem of the geographical maldistribution of physicians. Since there is only a finite number of patients, if the number of physicians in an area increases, then the number of patients signed up per doctor would decline and so would physicians' incomes. Therefore, there would be an incentive for physicians to locate their practices in underserved areas. Of course, this advantage is negated if physicians also have the option to set up a fee-for-service practice in the same area.

The Resource Allocation Group suggested that there should be differential capitation rates depending on various measurable values (age, sex, socioeconomic status, etc.). The idea behind this is valid: if you need to spend more time with a patient, then your reimbursement scheme should validate and encourage this. While it is easy to determine the age/sex breakdown of a physician's patient load, in practice it may be very difficult to do this for other factors. The bureaucracy required to ensure that the values were correctly calculated and tabulated might be enormous. Some of the values, e.g. socioeconomic

status, are difficult to measure at the best of times, and are open to interpretation. For instance, does a person's SES change if s/he marries or becomes unemployed. The basis for the differential capitation rates and the rates themselves would also have to be negotiated with physicians making the process very complicated.

The idea behind differential capitation rates for different groups of patients is that some people, e.g. low income individuals, are less healthy than others and therefore should be heavier users of the system. However, it is often the case that these same people underuse physicians' services relative to their need. In order to justify the larger differential, physicians should ideally institute programs to try and deliver care proportionate to need. How would such a system be monitored to ensure that this ideal was being achieved?

It was suggested that a capitation scheme should have a maximum number of patients enrolled. Again, we find it difficult to imagine how this would be carried out. As we all know, some patients take more time than others, and some services are more time consuming than others. Depending on the shape of the practice, the maximum would vary widely, and be difficult to enforce. If you were already at the maximum, would the Ministry accept the spouse or newborn of a rostered patient? If not, then the concept of delivering care to the entire family would suffer.

There are justifiable concerns about the public's input into what is, in fact, a private enterprise system of medicine. One response to this would be to look at the possibility of a community advisory board attached to the clinic or a group of clinics that coordinated their services. Many successful physicians already to this on an informal basis.

Salary

The paper suggested that standards of volume and quality of care be established. We would suggest that this is more appropriately the domain of the CPSO, which now has substantial public input on its Board. If it is possible to define these standards, then they should be universal and not just for salaried physicians. Furthermore, there is good evidence that physicians will only accept standards if they have been developed by their peers.

A positive aspect of the exercise to develop standards would be to eliminate

services that are not helping or contributing to the health of the population. Unfortunately, sometimes in salaried primary care positions (mostly CHCs) there is an incentive to add services if the Ministry will pay for them, without necessarily evaluating them beforehand to see if they are, in fact, necessary.

A major problem with the salary positions is that there is no incentive to be efficient in the use of time and services. Many of the patients are more difficult than those in a normal general practice, but then there is also more staff to deal with them. Is it possible to look at the efficiency and effectiveness of the team approach used in CHCs?

As with capitation, we are also concerned as to how the quality of clinical services would be monitored and by whom. The practices of capitated and salaried physicians can be monitored more closely than can those of fee-for-service doctors. Governments may therefore be tempted to set overly rigid standards in order to ensure that they are getting value for their money. We are already seeing some of this in the current negotiations over the future of HSOs.

Finally, while we believe that capitation and/or salary are inherently superior methods of paying physicians, the evidence that we have seen does not show any major difference in patient outcomes regardless of the method of payment.

As we stated at the beginning, we applaud the Resource Allocation Group's beginnings with this issue. Our comments are meant to expand on their work, and hopefully, add to the debate. ▼

Steering Committee Activities

STEERING COMMITTEE MEMBERSHIP

Andy Oxman stepped down from the Steering Committee after several years' service. Two new members have joined the Steering Committee: Vera Tarman and Chris Jinot. Additional members are still needed. The Steering committee meets monthly, alternating between Toronto and Hamilton. Anyone interested in joining the Steering Committee should speak to a present Steering Committee member or call (416) 588-9167. The current members of the Steering Committee are: Mimi Divinsky, Murray Enkin, John Frank, Gord Guyatt, Chris Jinot, Haresh Kirpalani, Rosana Pellizzari, Jim Sugiyama, Vera Tarman, and Rob Chase.

CONTACTS WITH THE MINISTRY OF HEALTH

Rosana Pellizzari and Gord Guyatt met with Michael Decker, the deputy minister of health, during the summer, to discuss cost-cutting by the Ministry and other issues. Steering Committee members have also pursued other phone and written contacts with the Ministry.

Mimi Divinsky and Rosana Pellizzari met with Larry Korea, an official in the Ministry of Health who deals with OHIP policy. The MRG had requested the meeting to talk about the list of procedures which were apparently being reviewed to see whether they should continue to be covered by OHIP. A report of this meeting was published in the September issue of *Medical Reform*.

CAMPAIGN FOR MEDICARE IN THE U.S.

A guest at the May meeting was David Himmelstein of the U.S. organization Physicians for a National Health Program (PNHP). Dr. Himmelstein spoke about what is happening in the campaign to bring medicare to the United States. He noted that the United States is now spending 14% of its GNP on health care, as opposed to slightly over 9% in Canada. The most expensive component of an American automobile is now health care, not steel. PNHP are trying to show physicians that their interests are opposed to those of the insurance companies on the question of ad-

ministrative fees and clinical autonomy. PNHP has put forward the 'Canadian model' in the U.S. debate not because the Canadian model is perfect, but because they felt it was important to be able to point to an actual working model rather than to be seen as talking pure theory. David Himmelstein said that neither the Republicans nor the Democrats have any intention of bringing in medicare.

ONTARIO HEALTH COALITION

Two members of the Ontario Health Coalition, Janet Maher and Lee Zaslofsky, spoke about the re-birth of the coalition, and the issues with which it was concerning itself. A major factor is the funding cuts imposed by the federal Progressive Conservative government, which will put an end to federal medicare payments within the next decade. This will mean that there is no mechanism to penalize provinces which fail to abide by the standards of the Canada Health Act. Provinces may bring in user fees, extra-billing, etc. and a medicare program with national standards will no longer exist. The Canadian Health Coalition is fighting these cuts on a national level, and trade unions are also very concerned. CUPE is organizing a

coalition to preserve medicare. Governments of all political persuasions have bought the line that there is no money to pay for social programs and that people are already overtaxed, so it is impossible to raise revenues and therefore services and wages have to be cut. This issue has to be confronted with an alternative analysis.

ABORTION ACCESS

Steering Committee spokeswoman Mimi Divinsky was quoted in the Canadian Medical Association Journal of August 15 on the issue of abortion access: "There is no doubt that takeovers of hospital boards by anti-abortion forces present an interesting problem to health care reformers. Dr. Mimi Divinsky, a Toronto family physician who speaks on the abortion issue for the 200-member Medical Reform Group, says 'hospitals must be accountable to the community they serve and election of hospital boards is an important part of democratization of the health care system. However, the anti-abortion forces don't express community values - they're just using the abortion question as a political football.' She supports the CARAL position that abortions need not be performed in hospitals."▼

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